Bellmawr Board of Education - Medical Plan Options - Effective January 1, 2020

	POS 15/25		HMO 10	
Benefits	**In-Network Benefits**	**Out-Of-Network Benefits**	**In-Network Benefits**	**Out-Of-Network**
Deductible	$0 Ind/$0 Family	$100 Ind/$250 Family	$0 Ind/$0 Family	**Emergencies Covered Out of Network Only**
Out of Pocket Limit	$400 Ind/$1,000 Family	$2,000 Ind/ $5,000 Family	$5,300 Ind/$10,600 Family	
Primary Care	$15 Copay	70% After Deductible	$10 Copay	
Specialist	$25 Copay	70% After Deductible	$10 Copay	
Chiropractic Care	$25 Copay (30 Visits)	70% After Deductible	$10 Copay (20 Visits)	
Preventive Care	Covered 100%	70% After Deductible	Covered 100%	
Diagnostic (x-ray, blood work)	Covered 100%	70% After Deductible	Covered 100%	
Imaging (CT/PET scans, MRIs)	Covered 100%	70% After Deductible	Covered 100%	
Outpatient Surgery Facility Fee/Physician/Surgeon Fees	$200 Copay	70% After Deductible	Covered 100%	
Emergency Room	$100 Copay Per Visit	$100 Copay Per Visit	$35 Copay Per Visit	
ER Transportation	Covered 100%	Covered 100%	Covered 100%	
Urgent Care	$25 Copay Per Visit	70% After Deductible	$10 Copay Per Visit	
Hospital Stay Facility Fee/Physician/Surgeon Fees	Covered 100%	70% After Deductible	Covered 100%	
Mental/Behavioral Health **Substance Abuse- Outpatient**	$25 Copay Per Visit For Mental Health Covered 100% For Substance Abuse	70% After Deductible	$10 Copay Per Visit For Mental Health Covered 100% For Substance Abuse	
Mental/Behavioral Health **Substance Abuse- Inpatient**	Covered 100%	70% After Deductible	Covered 100%	
Maternity Prenatal/Postnatal Care Delivery/Inpatient	$25 Copay Per Pregnancy For Initial Visit Covered 100% For Inpatient Services	70% After Deductible	$10 Copay Per Pregnancy For Initial Visit Covered 100% For Inpatient Services	
Home Health Care	Covered 100%	70% After Deductible, 60 Visits	Covered 100%	
Rehabilitation Services	$25 Copay Per Visit	70% After Deductible	$10 Copay Per Visit (60 Visits)	
Habilitation Services	$25 Copay Per Visit	70% After Deductible	$10 Copay Per Visit	
Skilled Nursing Care	Covered 100% (120 Visits)	70% After Deductible (60 Visits)	Covered 100% (120 Visits)	
Durable Medical Equipment	90% Covered	70% After Deductible	0% Coinsurance After $100 Deductible	
Hospice Service	Covered 100%	70% After Deductible	Covered 100%	
Eye Exam - 1 routine exam per calendar year	$25 Copay Per Visit	Not Covered	$10 Copay Per Visit	
Coverage Level	**PPO 15/25 Monthly Rates 1/1/20 - 6/30/20**		**HMO 10 Monthly Rates 1/1/20-6/30/20**	
Single	$758.00		$763.00	
Employee & Child(ren)	$1,244.00		$1,240.00	
Employee & Spouse	$1,509.00		$1,506.00	
Family	$2,003.00		$2,003.00	

Preauthorization may be required for certain services.

PLEASE NOTE - This overview is being provided for informational purposes only and does not contain all the terms, conditions, exclusions and limitations of the insurance carrier's policy. Complete details of your program appear in the policy provided by the carrier, which govern the benefits and operation of your program. The policy supersedes if there should be any inconsistency or difference between its provisions and the information in this overview.